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VALID CONSENT TO MEDICAL TREATMENT: NEED THE PATIENT KNOW?

Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent, commits an assault for which he is liable in damages.¹

v.

The law does not insist that a surgeon shall perform every operation according to plans and specifications approved in advance by the patient, and carefully tucked away in his office safe for courtroom purposes.²

INTRODUCTION

There are many legal implications, not the least being the issue of informed consent, inherent in the consensual relationship of physician and patient.³ It is generally agreed that a physician must obtain the patient's consent before proceeding with treatment;⁴ otherwise he subjects himself to the risk of liability for malpractice⁵ or assault and battery.⁶ Consent to treatment need not be express, but can be either implied from the facts arising from the contacts and dealings between physician and patient,⁷ or implied by law as in emergency situations.⁸ However, another issue that must be resolved is the validity of consent to medical or surgical treatment. More specifically, can any consent to treatment, whether express or implied, constitute valid authorization to the physician unless the patient understands the scope and extent of his consent?

This question will be considered in that situation where a normal adult patient confronts a physician, requesting consultation, advice and treat-

1. *Schloendorff v. Society of New York Hospital*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914).

2. *Barnett v. Bachrach*, 34 A.2d 626, 628 (D.C. Mun. Ct. App. 1943).

3. *Russell v. Harwick*, 166 So. 2d 904 (Fla. App. 1964).

4. See HAYT, HAYT & GROESCHEL, *LAW OF HOSPITAL, PHYSICIAN AND PATIENT* 253 (2d ed. 1952); SHARTEL & PLANT, *THE LAW OF MEDICAL PRACTICE* § 1-05 (1959); *HOSPITAL LAW MANUAL, Consents I* (1959); McCoid, *A Reappraisal of Liability for Unauthorized Medical Treatment*, 41 MINN. L. REV. 381 (1957); Smith, *Antecedent Grounds for Liability in the Practice of Surgery*, 14 ROCKY MT. L. REV. 233 (1942); Comment, 29 ALBANY L. REV. 342 (1965).

5. See e.g. *Natanson v. Kline*, 186 Kan. 393, 350 P.2d 1093, 187 Kan. 186, 354 P.2d 670 (1960); *Ditlow v. Kaplan*, 181 So. 2d 226 (Fla. App. 1966).

6. See e.g. *Bang v. Charles T. Miller Hospital*, 251 Minn. 427, 88 N.W.2d 186 (1958); McCoid, *A Reappraisal of Liability for Unauthorized Medical Treatment*, 41 MINN. L. REV. 381, 392 (1957).

7. E.g. *O'Brien v. Cunard Steamship Co.*, 154 Mass. 272, 28 N.E. 266 (1891); *McGuire v. Rix*, 118 Neb. 434, 225 N.W. 120 (1929).

8. E.g. *Luka v. Lowrie*, 171 Mich. 122, 136 N.W. 1106 (1912); *Jackovich v. Yocom*, 212 Iowa 914, 237 N.W. 444 (1931).

ment. In those physician-patient relationships involving an emergency, a minor patient, or a patient that is *non compos mentis*, the question of whether the patient understands what the physician intends to do is irrelevant since in these instances the patient is either unable or deemed incapable of granting consent.⁹ Therefore, the patient must be sufficiently capable of exercising his powers of judgment and choice before the issue of informed consent becomes meaningful.

The legal standards for ascertaining whether informed consent has been given are in some conflict; the application of the various rules are not consistent; and the total result is uncertainty for both the physician and patient. Further, revised legal standards as well as increased guidance to physicians by legal counsel can accomplish at least a partial solution to the problem.

THE NATURE OF INFORMED CONSENT

If it is first accepted that one has a right to determine what shall be done with his own body, and can either accept or refuse medical or surgical treatment, it would apparently follow that such a choice could be deemed valid only when the person has sufficient understanding of the considerations involved to make an intelligent choice.¹⁰ If that choice is to submit to treatment and the physician is authorized by the patient to commence treatment, it can be said that the patient gave his informed consent to be treated. Informed consent may then be defined as authorization to proceed with treatment given to a physician by a patient who knows and understands the risks and consequences that the treatment entails.

It is generally understood that a physician has a duty to disclose to his patient the results of diagnosis and the risks and consequences involved in proposed treatment.¹¹ However, a physician is apt to be somewhat concerned about the extent of disclosure he must make. Several cases occurring within the past few years, in a single jurisdiction, serve to illustrate that the physician's concern is well founded.

In 1958, in *Zaretsky v. Jacobson*,¹² the Third District Court of Appeals

9. In *Littlejohn v. Arbogast*, 95 Ill. App. 605 (1901), and *Cotnam v. Wisdom*, 83 Ark. 601, 104 S.W. 164 (1907), consent was held to be implied in law when it was impractical to consult relatives of adult patients who were unable to give consent and there was an imminent threat to life or health. In *Luka v. Lowrie*, and *Jackovich v. Yocom*, *supra* note 8, the patients were minors whose parents could not be contacted and there was an imminent threat to life or health. For a case that considered collaterally the problem of obtaining consent in a situation where the patient was insane, see *Pratt v. Davis*, 224 Ill. 300, 79 N.E. 562 (1906).

10. *Natanson v. Kline*, *supra* note 5, at 1104.

11. 41 AM. JUR. *Physicians and Surgeons* § 73 (1942); SHARTEL & PLANT, *THE LAW OF MEDICAL PRACTICE* § 1-05 (1959).

12. 99 So. 2d 730 (Fla. App. 1958).

of Florida held that a patient, injured as the result of a surgical procedure called an aortagram, stated a cause of action by alleging that he had not consented to such a highly technical and dangerous operation. In the *Zaretsky* case the court relied on established precedent that a doctor could not operate without express or implied consent, or in a manner contrary to the patient's expressed instructions.¹³ The patient voluntarily submitted to an operation, but apparently the court did not consider this submission as constituting implied consent to the aortagram.

Five years later the same court, in *Bowers v. Talmage*,¹⁴ considered the complaint of parents whose nine year old son suffered partial paralysis as a result of an arteriogram. The parents alleged that the arteriogram was a dangerous procedure and that the consent they extended for the procedure was not informed consent and was therefore invalid. The court held that the physician is under a duty to adequately inform the patient or, as in this case, the parents of a minor patient, of all the dangers inherent in an operation. There was no evidence that the parents were informed of the dangers incident to an arteriogram. The court relied upon the *Zaretsky* case and *Woods v. Brumlop*¹⁵ in concluding that unless a person giving consent to an operation knows of the degree of danger the consent is invalid.

In 1964, this court was again called upon to decide whether the patient had given informed consent. In *Russell v. Harwick*,¹⁶ damages totaling \$100,000 were awarded to the patient and her husband upon a finding that the surgeon had not told her that as a result of the necessary operative procedure her injured leg would be somewhat shorter than her healthy leg. The patient testified that she relied upon the surgeon to do whatever was necessary to relieve her condition, and it was established that the procedure finally adopted by the physician followed unsuccessful attempts to manipulate the injured hip in an alternative manner. Expert witnesses testified that the final procedure was warranted under the circumstances, was a well known and accepted procedure, and was skillfully performed. However, the patient testified that had she known that a shortening of her leg would result she would have requested further consultation before submitting to the operation. This testimony was sufficient for the court to conclude that the jury could have found there was no informed consent.

In 1966, the same court, in *Ditlow v. Kaplan*,¹⁷ affirmed a judgment for a physician upon the grounds that the plaintiff-patient had failed to show that it was accepted practice in the community for gastroenterol-

13. *Chambers v. Nottebaum*, 96 So. 2d 716 (Fla. App. 1957); *Wall v. Brim*, 138 F.2d 478 (5th Cir. 1943).

14. *Bowers v. Talmage*, 159 So. 2d 888 (Fla. App. 1963).

15. 71 N.M. 221, 377 P.2d 520 (1962).

16. *Supra* note 3.

17. *Ditlow v. Kaplan*, *supra* note 5.

ogists and physicians to advise their patients that perforation of the esophagus was a risk inherent in a gastroscopic procedure. In this case the patient had knowledge that the procedure involved some risk, but was not informed of the possibility that her esophagus could be punctured. The court recognized *Bowers v. Talmage*¹⁸ as precedent requiring the physician to adequately inform the patient of dangers inherent in an operation, but held that the standard to be applied in ascertaining whether the physician had fulfilled his duty was the accepted practice of other physicians in the community. In requiring that proof of the community standard be provided through expert witnesses before recovery would be allowed, the court relied upon recent cases from Delaware,¹⁹ Kansas,²⁰ Michigan²¹ and Wyoming.²² Therefore, it would appear that the Third District Court of Appeals of Florida has come full circle between *Bowers v. Talmage* in 1963 and *Ditlow v. Kaplan* in 1966. In *Bowers* the court said, "unless a person who gives consent to an operation knows its dangers and the degree of danger, a 'consent' does not represent a choice and is ineffectual."²³ The subjective nature of this test for informed consent appears to be quite different from the "community standard" applied by the *Ditlow* court. A court, in applying the subjective standard of *Bowers*, must find that the patient knew the risks and consequences of the treatment and intelligently consented to such treatment, or else that the patient did not want to know, or waived disclosure in consenting to treatment. This finding is not the same as that required in *Ditlow*. The *Ditlow* test would merely require the physician to show that he disclosed, to his patient, substantially the same information as do other physicians under similar circumstances. When the latter standard is used, there is no real requirement that the patient be able to make an intelligent decision based upon substantial information of alternative choices. Consent in this instance merely means that the patient must decide whether to accept treatment upon the basis of what is disclosed by the physician, whether this information is sufficient grounds for an intelligent decision or not.

The fact that the four cases previously discussed have a common jurisdiction is not intended as an indication that the problem is in any way limited to that jurisdiction. On the contrary, the question of informed consent has arisen in a substantial number of states and has been decided in a variety of ways. By far the majority of jurisdictions treat the issue as incident to malpractice.²⁴ However, the issue of informed consent has

18. *Supra* note 14.

19. *DiFilippo v. Preston*, 53 Del. 539, 173 A.2d 333 (1961).

20. *Williams v. Menehan*, 191 Kan. 6, 379 P.2d 292 (1963).

21. *Roberts v. Young*, 369 Mich. 133, 119 N.W.2d 627 (1963).

22. *Govin v. Hunter*, 374 P.2d 421 (Wyo. 1962).

23. 159 So. 2d at 889.

24. See e.g. *Ditlow v. Kaplan*, *supra* note 5; *Aiken v. Clary*, 396 S.W.2d 668 (Mo. 1965);

also arisen in actions for assault and battery,²⁵ lack of consent,²⁶ and a combination malpractice-battery suit.²⁷ There are various standards applied in the several jurisdictions that in some ways conflict with, and to some extent complement, each other.

For example, a number of jurisdictions allow a patient to maintain a malpractice suit against a physician based upon the physician's failure to make a reasonable disclosure of dangers incident to the proposed treatment without the use of expert testimony to establish the "community standard" of disclosure. Thus, in a New York case,²⁸ a patient inflicted with rheumatoid arthritis was treated with injections of a gold compound that caused her to suffer from a skin condition. The court held that the possibility of causing the skin condition is a known danger incident to use of the gold compound and should have been brought to the attention of the patient before using it. While the court found that the possibility of undesirable reactions is recognized by the medical profession, it did not require evidence to establish that the danger would be normally communicated to patients by other members of the profession under like circumstances. Similarly, in *Woods v. Brumlop*,²⁹ a case involving consent to electroshock therapy, the court held that the relationship between physician and patient is one of trust and confidence requiring the physician to make a full and frank disclosure to the patient of all pertinent facts relative to the illness and the prescribed treatment. The court stated that the real reason for requiring disclosure is to give the patient a foundation upon which to base his decision.³⁰ In this case, as in the former, no expert testimony was required.

Significantly, the prior two cases were malpractice suits in which the community standard of the medical profession was regarded as the norm. Establishing the community standard usually requires expert testimony.³¹ However, there does appear to be some basis for dispensing with the requirement, as in these cases, where the nature of the wrong termed malpractice is not negligence or breach of professional ethics, but, rather, a wrong dependent upon considerations relating to whether the patient was

DiRosse v. Wein, 24 App. Div. 2d 510, 261 N.Y.S.2d 623 (1965); Block v. McVay, 80 S.D. 469, 126 N.W.2d 808 (1964); Williams v. Menehan, *supra* note 20; Woods v. Brumlop, 71 N.M. 221, 377 P.2d 520 (1962); Govin v. Hunter, *supra* note 22; DiFilippo v. Preston, *supra* note 19; Klien v. Arnold, 203 N.Y.S.2d 797 (Sup. Ct. 1960).

25. Bang v. Charles T. Miller Hospital, *supra* note 6.

26. Wilson v. Lehman, 379 S.W.2d 478 (Ky. 1964).

27. Bradford v. Winter, 215 Cal. App. 2d 448, 30 Cal. Rptr. 243 (1963).

28. DiRosse v. Wein, *supra* note 24. See also Scott v. Kaye, — App. Div. 2d —, 264 N.Y.S.2d 752 (1965).

29. Woods v. Brumlop, *supra* note 24.

30. *Id.* at 524.

31. See 20 AM. JUR. EVIDENCE §§ 775 *et seq.* (1942); 70 C.J.S. *Physicians and Surgeons* § 62 (1951).

informed to an extent necessary to enable him to make an intelligent decision.

Also, in this area, expert testimony need not be considered in an action for assault and battery. Thus, an allegation that the patient had not been informed that a prostate gland operation would involve severance of his spermatic cords was held to constitute assault and battery.³² It was held that where the surgeon can ascertain alternative situations in advance of an operation, and no emergency exists, the patient must be informed of the possibilities and permitted to decide for himself.

As previously stated, however, the majority of jurisdictions do require expert testimony where the issue is informed consent. The purpose of such testimony is to establish the standard of reasonable practice for a physician or specialist under similar circumstances. A leading case among jurisdictions accepting this procedure is *Natanson v. Kline*,³³ which involved a patient who sustained serious injury due to an excessive dose of cobalt irradiation therapy. The physician had made no disclosure of the dangers involved in such treatment and the court, reversing judgment for the physician, stated:

In our opinion the proper rule of law to determine whether a patient has given an intelligent consent to a proposed form of treatment by a physician . . . compels disclosure by the physician in order to assure that an informed consent of the patient is obtained. The duty of the physician to disclose, however, is limited to those disclosures which a reasonably prudent medical practitioner would make under the same or similar circumstances.³⁴

The language in the *Natanson* opinion seems to indicate the disclosure is mandatory and must substantially conform to disclosures that would be made by other members of the medical profession under similar circumstances. This is the standard for determining adequate disclosure. Such a standard relied heavily upon the medical profession's recognition of its obligations to maintain adequate criteria for disclosure. Measuring the sufficiency of disclosure in these terms makes the patient entirely dependent upon the medical profession for protection of his right to be informed. In essence, the profession determines what a patient is to be told. However, the court apparently considered the interests of the patient sufficient to warrant laying down guidelines for the medical profession. In discussing the extent of information that must be disclosed to the patient the court stated:

32. *Bang v. Charles T. Miller Hospital*, *supra* note 6.

33. *Supra* note 5.

34. *Natanson v. Kline*, *supra* note 5, at 1106.

In considering the obligations of a physician to disclose and explain to the patient in language as simple as necessary the nature of the ailment, the nature of the proposed treatment, the probability of success or of alternatives, and perhaps the risks of unfortunate results and unforeseen conditions within the body, we do not think the administration of such an obligation, by imposing liability for malpractice if the treatment were administered without such explanation where explanation could reasonably be made, presents any insurmountable obstacles.³⁵

The court in *Natanson* relied to some extent upon *Slago v. Leland Stanford, Etc. Bd. Trustees*,³⁶ which involved a patient who suffered partial paralysis as a result of a procedure known as an aortography. The patient alleged that neither the details of the procedure nor its dangers were explained to him. The trial court gave instructions to the effect that the physician has a duty to disclose all facts that mutually affect his and the patient's rights and interests as well as the surgical risks, hazards and dangers involved. On appeal the court held that the instructions were too broad and stated:

A physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment. Likewise the physician may not minimize the known dangers of a procedure of operation in order to induce his patient's consent. At the same time, the physician must place the welfare of his patient above all else and this very fact places him in a position in which he sometimes must choose between two alternative courses of action. One is to explain to the patient every risk attendant upon any surgical procedure or operation, no matter how remote; this may well result in alarming a patient who is to undertake surgery in which there is in fact minimal risk; it may also result in actually increasing the risks by reason of the physiological results of the apprehension itself. The problem, that the patient's mental and emotional condition is important and in certain cases may be crucial, and that in discussing the element of risk a certain amount of discretion must be employed consistent with the full disclosure of facts necessary to an informed consent.³⁷

The position of the Kansas and California courts affords recognition to the right of the patient to have information enabling him to decide between accepting treatment and its risks or suffering the consequences

35. *Natanson v. Kline*, *supra* note 5, at 1106-1107.

36. 154 Cal. App. 2d 560, 317 P.2d 170 (1958).

37. *Id.* at 578, 317 P.2d at 181.

of his ailment. Yet the courts appear to feel that what the patient should be told is a matter for medical opinion. Thus, there appears to be a willingness on the part of the courts to permit the physicians a certain amount of discretion in deciding the nature and content of the disclosures.

Somewhat more removed from the theory of absolute duty to disclose the risks and consequences of treatment are those courts requiring that the patient provide expert testimony to establish the nature of the disclosure customarily made by the medical profession in warning of certain dangers inherent in the operation or treatment that the patient has undergone.³⁸ For example, *Govin v. Hunter*³⁹ involved an action for damages based upon malpractice. The patient alleged that the physician failed to fully disclose the number of incisions required to successfully complete the operation. As a result of the operation the patient's leg was scarred and disfigured. Thus it was alleged that the physician breached a duty in not informing the patient that multiple incisions would be necessary to complete the operation, thereby depriving her of the right to decide whether she would submit to such an operation. The court held that the custom of the medical profession must be established by expert testimony. Furthermore, unless there is expert testimony, the want of care necessary for liability for malpractice could not be decided by a jury, since, without expert testimony there would be no basis for finding that a duty had been breached.

The rules relied on by courts in deciding whether authorization for treatment is valid (based upon informed consent) may be summarized as including three general standards. (1) The jurisdictions that follow the reasoning of the *DiRosse* and *Woods* cases apply the "subjective" test. They rely on the nature of the risks and consequences inherent in specific surgical or medical treatment, and concern themselves with determining whether the individual patient was sufficiently apprised of the risks. (2) The second group of courts accept the premise that a physician has a duty to make a disclosure that enables the patient to give informed consent. They require the patient to produce medical testimony that establishes what disclosures are reasonable in light of community medical practice. The courts do not, however, stop here. As illustrated by the *Natanson* and *Slago* cases, there are minimum limits placed upon the medical profession. More specifically, the courts describe the nature of the disclosures that should be made and rely on the medical profession to police themselves in fulfilling the obligations owed to patients. (3) The third group of cases apply a more liberal standard. While requiring disclosure and informed consent to treatment, they hold that before the

38. *DiFilippo v. Preston*, *supra* note 19; *Haggerty v. McCarthy*, 344 Mass. 136, 181 N.E.2d 562 (1962); *Govin v. Hunter*, *supra* note 22; *Aiken v. Clary*, *supra* note 24; *Ditlow v. Kaplan*, *supra* note 5.

39. *Supra* note 22.

patient can recover damages for malpractice arising from the physician's failure to make an adequate disclosure, the patient must show that the physician did not meet the standard of practice of other physicians in the community. Using this standard, the courts place full reliance upon the medical profession and its ability to protect the patient's right to an adequate disclosure.

DEFECTS IN THE PRESENT STANDARDS

Each of the three standards has a defect that causes some uncertainty in the guidelines it furnishes the physician or surgeon. The subjective test appears to provide the greatest assurance that the right of the individual patient to be informed will be protected by the courts. In practical application, however, it constitutes an impossible standard of conduct for a physician or surgeon. It requires that the physician sufficiently apprise each individual patient of the possible risks and consequences of proposed treatment, in a manner that will assure the patient's ability to intelligently determine whether to submit to treatment. This standard can be applied in a manner that would require the physician to be able to detect the slightest misunderstanding on the part of his patient. A uniform application of such a standard may very well have the effect, contemplated by at least one court, of causing the physician to defer exercise of professional discretion during the course of treatment.⁴⁰

The third standard, which depends solely upon expert testimony, has the opposite effect upon the physician-patient relationship. It encourages exercise of discretion on the part of the medical profession. Thus, it permits the various segments of the medical community to establish their own standard for patient disclosures. This criterion can prevent the physician from telling the patient anything that may cause him to become apprehensive. Instead of fostering trust and confidence between physician and patient, such a standard may have the opposite effect. By ignoring the individual patient, it may foster distrust of the medical profession by the general public.

The test outlined in the *Natanson* case appears to be the most satisfactory of the three approaches. It requires disclosure of a definite nature and at the same time relies to a great extent upon the medical profession's integrity. However, the standard can be applied to have the same effect as the test based entirely upon the testimony of expert witnesses.⁴¹

Additional inconsistency in the standards for establishing informed consent exists in this area. The basic problem of informed consent should

40. See *Barnett v. Bachrach*, *supra* note 2.

41. See *Ditlow v. Kaplan*, *supra* note 5, where the court cites the *Natanson* case and yet appears to require expert testimony to establish a standard for disclosure without limiting such standard as did the court in the *Natanson* case.

be treated on an individual patient basis since the issue necessarily involves a determination of whether a particular patient was sufficiently apprised of the nature of treatment to understand, in a general way, what his consent involved. The issue does not involve negligence on the part of the physician, for, in many of the cases allowing recovery, the procedures were skillfully accomplished and acceptable to the medical profession.⁴² Also, because of the wide cross-section of persons who may be patients, it seems highly unlikely that any rigid standard for disclosure among the medical community would insure that the less educated person would understand the nature of the proposed treatment. The requirement of medical testimony to establish a standard of disclosure, therefore, seems inappropriate in determining the issue of informed consent and differs substantially from the issue of standard of care in executing a surgical procedure or prescribing a drug.

Another matter of some importance is the extent of disclosure that must be made. Of what risks and consequences must the patient be apprised? The subjective standard would require that this matter depend upon the capacity of the individual patient to appreciate the comparison of minute risks and unlikely consequences. The *Ditlow* standard would allow the medical community to determine what incidence of risks and probability of consequences were of sufficient magnitude to be called to the attention of the patient. Both standards are somewhat uncertain to the individual physician. Perhaps the most practical standard is that enunciated in the *Slago* case. While allowing the physician a wide latitude of discretion in how he should undertake the education of his patient, that standard, nonetheless, requires him to make available to the patient any facts that are necessary for an intelligent consent and prohibits him from minimizing proven dangers in treatment.

CONSIDERATIONS FOR A REVISED STANDARD

The following comments are proposals for a revised standard to be used in determining the issue of informed consent to medical and surgical treatment.

First, the rule stated in the earlier cases concerned with consent to surgical procedures⁴³ and its modification by several recent cases that are more specifically involved with informed consent to treatment⁴⁴ recognizes that every normal adult has a right to decide whether he will submit his body to proposed medical or surgical treatment. Before voluntary submission to treatment will be deemed to constitute valid consent, he must

42. *E.g.* *Russell v. Harwick*, *supra* note 3.

43. See *Mohr v. Williams*, 95 Minn. 261, 104 N.W. 12 (1905); *Rolater v. Strain*, 39 Okla. 572, 137 Pac. 96 (1913); *Schloendorff v. Society of New York Hospital*, 211 N.Y. 125, 105 N.E. 92 (1914).

44. See *e.g.* *Slago v. Leland Stanford, Etc. Bd. Trustees*, *supra* note 36.

be apprised of any facts that are necessary to form the basis of an intelligent consent to proposed treatment.

The object of using expert testimony should be to establish those risks and consequences that are incident to a specific procedure or treatment. While there are general risks of infection, death and impairment of mobility of body parts inherent in any operation, it is uniquely within the ability of the medical profession and its specialties to relate specific risks or consequences to a proposed method of treatment, and to inform the jury and the court of the probability that a specific risk or consequence will result from a certain procedure. This testimony would allow a jury of laymen to arrive at the magnitude of the risk by correlating the nature of the risk or consequence to the probability of its occurrence. Thus, it may be said that a consequence, such as shortening of a limb, which will almost certainly follow a specific procedure, would be a risk of sufficient magnitude to compel disclosure,⁴⁵ while the disclosure of the risk of perforating the esophagus during an exploratory operation, since it is a rather rare occurrence and of slight consequence, would be excused.⁴⁶ Although such a test would allow the jury some latitude in determining whether disclosure of a particular aspect of treatment was to be compelled, it would seem that this test would afford the physician a more concrete basis for determining the content of the disclosure than the subjective test, while simultaneously guaranteeing that the patient will be told matters that are of reasonable significance.

It should not be necessary for the physician to describe every facet of an operative procedure to the patient. The subject of disclosure should parallel that outline set forth in the *Natanson* case, including the general nature of proposed treatment, probability of success, alternative procedures, general risks and probable consequences, and the possibility that unforeseen conditions may necessitate a change in procedure not contemplated at the outset. Such disclosure, when made in a manner that best suits the individual patient, can assure the physician that the patient has placed his trust in the physician's ability and should also enable the physician to obtain valid consent authorizing him to perform both the contemplated operation and any unforeseen operative procedures that may materialize during the course of the primary procedure.

Courts must be aware of the physician's need to use general rather than technical or specific explanations. This generality is required for two reasons: first, because of the inability of the average person to comprehend the exact nature of medical and surgical treatment, and also because use of general terms will enable a physician to arouse the patient's awareness that certain procedures involve a substantial amount of danger without

45. See *Russell v. Harwick*, *supra* note 3.

46. See *Ditlow v. Kaplan*, *supra* note 5.

having to detail every possible result, thereby causing the patient to become unnerved at the thought of the procedure.

Another aspect of the physician-patient relationship that must be considered is the need for the patient to derive the greatest amount of therapeutic benefit possible. The court should recognize that the physician may be excused from making a full and frank disclosure to an unduly apprehensive patient.⁴⁷ However, since this condition would be an exception to the requirement of disclosure, the burden should fall upon the physician to prove that limited disclosure was warranted under the circumstances.

A standard incorporating the above proposals would allow a jury to determine whether the patient was sufficiently informed to give an effective consent to a specific treatment. In effect, the subjective standard would be retained in that the jury would have to determine whether the individual patient was made aware of a sufficient number of facts to make an intelligent decision. Yet, the uncertainty inherent in the standard as applied in *DiRosse* and *Bang*⁴⁸ would to some extent be cured by requiring expert testimony to establish the magnitude of the risk or consequence that allegedly was not communicated to the patient. In addition, the illogical requirement of expert testimony to establish a standard of care would be unnecessary. This procedure should help preserve the attention given to the individual on a patient by patient basis, and at the same time eliminate the disregard for individual traits of patients in order to preserve the freedom of judgment in the medical profession.

CONCLUSION

The instability of presently established standards for determining the issue of informed consent is indicated by the changes that occurred in Florida within a relatively short period of time. A great number of states have similar rules, and in those states that apply different standards there is need for revision because of the uncertainty that is created by the practical application of such rules to the physician-patient relationship.

The requirement of expert testimony to establish a standard of practice is somewhat out of place even though the majority of informed consent issues arise in malpractice suits. The issue itself is basically individual in nature and, in the interest of logically resolving the issue in a manner that affords recognition to the wide cross-section of patients, expert testimony should be used to establish the nature of treatment in the context of the magnitude of risks and consequences incident to specific treatment. Such a test would best serve the interests of the physician and the patient, for

47. See e.g. *Dicenzo v. Berg*, 340 Pa. 305, 16 A.2d 15 (1940); *Natanson v. Kline*, *supra* note 5; *Slago v. Leland Stanford, Etc. Bd. Trustees*, *supra* note 36.

48. *Bang v. Charles T. Miller Hospital*, *supra* note 6.

it would afford the physician a more concrete basis for determining content of disclosure and at the same time take into account the needs of the individual patient.

Charles J. Weyandt